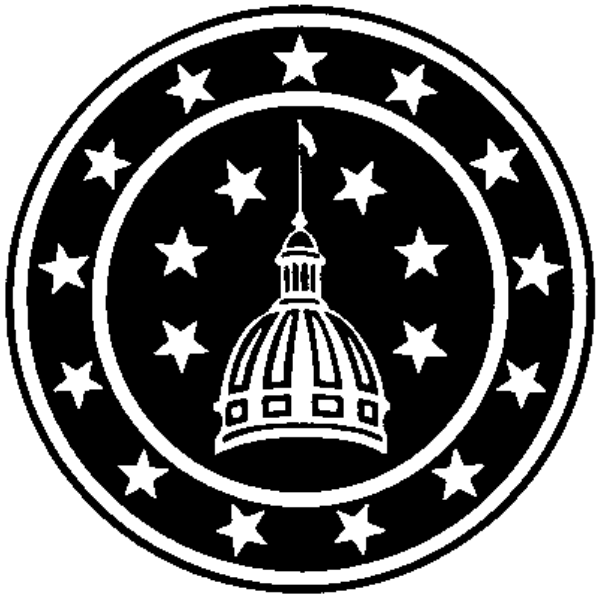
FINAL REPORT

OF THE

HEALTH FINANCE COMMISSION



Indiana Legislative Services Agency
200 W. Washington St., Suite 301
Indianapolis, Indiana 46204-2789

November, 2004

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2004

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Health Finance Commission

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November 1, 2004

A copy of this report is available on the Internet. Reports, minutes, and notices are organized by committee. This report and other documents for this Commission can be accessed from the General Assembly Homepage at http://www.state.in.us/legislative/.

FINAL REPORT

Health Finance Commission

I. STATUTORY AND LEGISLATIVE COUNCIL DIRECTIVES

The Indiana General Assembly enacted legislation establishing the Health Finance Commission to study health finance in Indiana. The Commission may study any topic: (1) directed by the chair of the Commission; (2) assigned by the Legislative Council; or (3) concerning issues that include the delivery, payment, and organization of health care services and rules that pertain to health care delivery, payment, and services that are under the authority of any board or agency of state government.

The Legislative Council assigned the following additional responsibilities to the Commission: (1) the viability of county hospitals (as proposed in HR 59); (2) generic drug pricing variances (as proposed in HR 76); and (3) Certificate of Need requirements for health facilities (as proposed in SR 54). Additionally, a progress report concerning the implementation of home and community-based services was required to be submitted to the Commission by SEA 449-2004.

II. INTRODUCTION AND REASONS FOR STUDY

House Resolution No. 76 urged the Health Finance Commission to study the viability of maintaining county-owned hospitals or county-operated hospitals. Representative Ralph Foley introduced the resolution in response to his concern that the expansion of specialty providers were expanding into county-owned hospital markets and eroding their private pay patient bases. Rep. Foley was concerned that a decrease in the private pay patients using county-owned hospitals would ultimately threaten their ability to provide services for the medically indigent in their communities and their long-term financial viability.

House Resolution No. 59 requested the Legislative Council to assign the Health Finance Commission the topic of pricing variance in generic drugs. Representative Charlie Brown introduced the resolution in response to reports that the same generic drugs sold by different companies or even within the same company had prices that varied significantly. The variance in cost to uninsured or underinsured individuals was so great from location to location as surveyed by and subsequently reported in two Lake County newspapers, that Rep. Brown was concerned that consumers were being taken advantage of by pharmaceutical retailers.

Senate Resolution 54 urged the Health Finance Commission to study issues concerning requiring a certificate of need for or establishing a moratorium on health care facilities in Indiana.

The Commission was to study the following:

(1) The amount of cost savings that would result for the state by limiting the expansion of buildings for health care facilities.
(2) The financial losses incurred by the state and the construction industry if a certificate of need or a moratorium is established for health care providers.
(3) Whether health care costs for the state would be reduced if the state required a certificate of need for or implemented a moratorium on the

building of new health care facilities.
(4) The factors that have resulted in an increase in health insurance premiums in the state.
(5) The percentage of health care costs that are the result of construction costs for new or expanding health care facilities.
(6) The ability of community hospitals to deliver full, nondiscriminatory service and comprehensive care and whether this ability is affected by the establishment of health care sites, other than physician offices that provide a limited scope of medical or acute health services.
(7) The appropriateness and feasibility of requiring providers or health care sites, other than physician offices that provide a limited scope of medical or acute health care services, to help fund or provide care to a community's poor or vulnerable patients.

Senate Enrolled Act 449-2004 required the Office of the Secretary of the Family and Social Services Administration to report, in writing, to the Health Finance Commission the progress made in implementing IC 12-10-11 (provisions of SEA 493-2003). The noncode provision specifies elements of the report that must be included in the report which was to be submitted no later than May 1, 2004.

III. SUMMARY OF WORK PROGRAM

The Commission met three times during the 2004 interim.

The first meeting was held July 27, 2004, at the State House in Indianapolis. The meeting was devoted to hearing testimony concerning the unique role of county-owned hospitals in the provision of health care and the wide variance in the prices of generic drugs between drug stores and within retail pharmacy chains.

The second meeting was held August 30, 2004, at the State House in Indianapolis. The meeting focused on expert testimony addressing questions that arose at the previous meeting regarding the pricing variance of generic drugs sold to uninsured or underinsured individuals and the advisability of reimplementation of a Certificate of Need (CON) program to restrain health care cost increases.

The third meeting was held on September 29, 2004, at the State House in Indianapolis. The meeting was for the purpose of considering and approving legislative recommendations and the Commission's final report. The Commission heard continuing testimony regarding the reason for variances in generic drug prices. There was also a presentation of a progress report required by SEA 449-2004 regarding the implementation of home and community-based services required in SEA 493-2003, and testimony was heard regarding the lack of progress made by the agency in the implementation of several major requirements of SEA 493-2003.

IV. SUMMARY OF TESTIMONY

This section is a general summary of testimony received by the Commission on the issues assigned by the Legislative Council and required by SEA 449-2004. To read a more complete record of this testimony and other matters considered by the Commission, the minutes for the Commission's three meetings can be found on the homepage of the Indiana General Assembly (http://www.in.gov/legislative/) or copies

may be obtained by contacting the Legislative Information Center of the Legislative Services Agency.

The Viability of Maintaining County-Owned Hospitals or County-Operated Hospitals

Rep. Foley expressed his concern for the long-term survival of county-owned or operated hospitals if they are left as sole providers of emergency and indigent care in markets diminished by boutique providers and private specialty hospitals skimming privately insured, paying patients while government reimbursement continues to cover only a percentage of the actual cost of the care of their covered patients. Rep. Foley commented that serious consideration should be given to the role these hospitals play in the overall provision of healthcare in the state and what actions may be necessary to keep these institutions financially viable. County-owned hospitals do not levy taxes, (with the exception of the Health and Hospital Corporation). Matt Brooks of the Association of Indiana Counties explained that county-owned hospitals have been self-sufficient for many years. The hospitals are public entities with strong citizen support, as well as being major employers in their communities.

Rep. Foley further addressed the impact that eroded patient bases may have on the county hospitals' continued access to the capital markets necessary to finance renovations and updates to the institutions' physical plants. The fact that some bond issues for county-owned facilities have been backed by their counties leads to concerns that financial difficulties for the hospitals may lead to the counties being required to back defaulted hospital bonds.

Tim Kennedy, representing the Indiana Hospital and Health Association, reported that there are 119 acute care hospitals in the state; 35 of the total are county-owned hospitals, one is city-owned, and one is owned by the Health and Hospital Corporation, Wishard Hospital. He reported that 25 of the county-owned hospitals are the sole acute care provider in the counties in which they are located. Mr. Kennedy reviewed the governance structure of the county hospitals, which mainly differs in the method by which the governing bodies are selected. County hospitals are considered to be units of government and are subject to open door laws. With regard to access to capital markets, Mr. Kennedy reported that counties may guarantee bonds for their county hospitals, but the necessity of doing so depends on the financial position of the individual institution. He reported that about one-half of recent bond issues have required county backing.

Generic Drug Pricing Variances

Larry Sage of the Indiana Pharmacists Alliance explained that the size of the prescription drug market that is paid for in cash by consumers has been shrinking over the last 15 years and is anticipated to get smaller. He stated that nationally, in 1990, 63% of all prescriptions filled were paid for by the individual consumer; by 2003, only 14% of the prescription drugs sold were purchased at retail. With the implementation of the new Medicare Part D drug benefits, the remaining retail business will decline to an even smaller percentage.

Grant Monahan of the Indiana Retail Council remarked that the issue of varying prices for similar products from retailer to retailer and even across chain stores is a common occurrence; it is not unique to prescription drugs. He stated that retail pricing is a proprietary business decision that reflects the cost of doing business and that

consumers are free to compare prices and shop where they please.

Dr. Matthew Murawski, Associate Professor of Pharmacy Administration at Purdue University, reviewed a number of reasons that generic drug prices would vary from a given retailer, manufacturer, and at any given point in time. After reviewing the prescription drugs that the Northwest Indiana newspapers had included in the surveys that they conducted, he concluded that newspapers are in business to tell a "good" story, not necessarily a comprehensive story. He commented, in general, that if third-party contracts reduce the amount of profit margin available to pharmaceutical retailers, the remaining cash payers in the market will assume more of the burden in making up the companies' profit margins.

Mr. Bob Billings, Manager of Industry Affairs, Apotex Corporation, addressed the generic drug price variance issue from the perspective of a manufacturer of generic drug products. Mr. Billings reviewed the U.S. Food and Drug Administration process required to market a generic drug in the United States. He emphasized that FDA-approved and rated generic drugs should cause no different therapeutic response than the brand name drug. He stressed that from the manufacturer's perspective, generic drugs are sold in a commodities market; the price the manufacturer receives for the product is determined by the marketplace.

Certificate of Need

Testimony regarding the need to implement a certificate of need program (CON) or a temporary moratorium was mixed. The majority of witnesses preferred a moratorium with certain exceptions allowed. Zach Cattell, Legislative Liaison of the Indiana Department of Health, commented that when the Department operated a CON program, it lacked the staff and expertise necessary to provide the technical ability to actually determine need for health care facilities and services. Other speakers supported the ineffectiveness of the previous CON program. Mr. Cattell added that if an effective program were to be implemented, the resources assigned in the Michigan program might be indicative of those necessary to conduct an effective program in Indiana; 12-14 staff members and a budget in excess of $1 M.

Charles Hiltunen urged the Commission to consider the impact that a CON program might have on current state economic initiatives directed at biotechnology and life sciences industry growth. He pointed out the relationship between medical education, biotechnology, and large specialty hospitals where clinical trials are performed.

Tim Kennedy of the Indiana Hospital and Health Association (IHHA) stated that the IHHA has not yet taken an official position with regard to the implementation of a CON program this year. He discussed several other options the IHHA is considering for addressing the numerous concerns raised in the Commission discussions.

Testimony supporting the implementation of CON cited continuing high costs of employer-provided health insurance, examples of market saturation in high tech medical equipment, and reports of $2.7 B of planned medical construction projects in the state.

FSSA Report on the Implementation of SEA 493-2003

Annette Biesecker, Legislative Director, FSSA, reviewed a grid outlining the

implementation of SEA 493-2003. During the review, she commented that some steps could not be implemented unilaterally, but the requirements were performed to the extent that FSSA had determined possible. She reported that the Lewin Group had been engaged to analyze the fiscal impact of several key provisions of SEA 493-2003 in order to answer questions regarding fiscal feasibility from the Centers for Medicare and Medicaid Services (CMS). This report is expected to be completed by the end of November.

Testimony emphasized that FSSA had not implemented key provisions of the bill or had not worked to develop the providers necessary in order to make the services accessible. The Commission discussed the delay in the revision of the financial eligibility standard to 300% of SSI for the home and community-based services waiver, an action intended to equalize the financial incentives for home-based services with nursing facility admission. The Commission members asked Ms. Biesecker to arrange a meeting with Secretary Sullivan and State Budget Director Shultz to explain the lack of progress in the implementation of this legislation.

V. COMMITTEE FINDINGS AND RECOMMENDATIONS

The Commission considered the following legislative recommendations.

PD 3302 imposes a two-year moratorium on the construction or addition of: (1) comprehensive care beds; (2) ambulatory outpatient surgical centers; and (3) hospitals until June 30, 2007. PD 3302 was withdrawn from consideration by Chairman Charlie Brown.

PD 3310 would require a pharmacy to annually file proposed retail prices of generic legend drugs with the Board of Pharmacy. The draft legislation would require the Board to review and make a determination of approval or denial of proposed retail prices. PD 3310 was withdrawn by Chairman Charlie Brown.

PD 3337 would require the Board of Pharmacy to annually develop a schedule of reasonable prices for generic legend drugs and review a random sample of pharmacies for compliance. The draft legislation would require a pharmacy to annually file retail prices based on the schedule with the Board. The Chairman took testimony on the draft, and after Commission discussion, Rep. C. Brown withdrew PD 3337 from consideration.

PD 3345 expands the requirements that must be met by a wholesale drug distributor for eligibility for licensure in Indiana. The draft legislation specifies criminal acts related to wholesale drug distribution and legend drugs. Chairman Charlie Brown withdrew the draft after determining that the concept needed additional work.

PD 3386 would require hospitals to hold at least two public hearings after at least 10 days after a newspaper notice whenever expansion or construction is planned that will cost in excess of $10 M. Rep. Becker presented the draft; the Commission heard testimony and discussed the concept. A motion was made and seconded to recommend the introduction of PD 3386. The Commission voted 13-5 to recommend the draft.

PD 3394 would require a physician who has a direct or indirect interest in a service to which he refers a patient to disclose to the patient the physician’s ownership interest in

the service or business. Rep. Becker explained PD3394. The Commission discussed how the draft interfaced with federal legislation. A motion was made and seconded to recommend the introduction of the draft. The Commission voted 17-0 to recommend PD 3394.

The motion to adopt the final report with the inclusion of the September 29, 2004, meeting activity along with the vote record for preliminary drafts passed unanimously by voice vote.

W I T N E S S L I S T

July 27, 2004
Representative Ralph Foley
Representative Thomas Kromkowski
Tim Kennedy, Indiana Hospital and Health Association
Matthew Brooks, Association of Indiana Counties
Paul Clippinger, Morgan County Hospital and Medical Center
Larry Sage, Indiana Pharmacists' Alliance
Grant Monahan, Indiana Retail Council

August 30, 2004
Alice Dodd, representing Milburn Pharmacy and Home Center, Sullivan, IN
Matthew Murawski, R.Ph., Ph.D., Associate Professor of Pharmacy Administration, Purdue University
John Dietz, M.D., Ortho Indy
Jim Leich, Indiana Association of Homes and Services for the Aging
Steve Albrecht, Indiana Health Care Association
Zach Cattell, Legislative Liaison, Indiana Department fo Health
Bob Decker, Hoosier Owners and Providers for the Elderly
David Hale, United Auto Workers
Russ Towner, DaimlerChrysler and the Alliance of Automobile Manufacturers
Carol Blanar, Indiana Federation of Ambulatory Surgery Centers
Richard Fogle, M.D., The Care Group and the Heart Center of Indiana
Charles Hiltunen, Midwest Eye Institute, Beltway Surgery Centers
Tim Kennedy, Indiana Hospital and Health Association

September 29, 2004
Bob Billings, Manager of Industry Affairs, Apotex Corporation
Annette Biesecker, Legislative Director, Family and Social Services Administration
John Cardwell, Chairman, Indiana Homecare Taskforce
June Lyle, AARP
Paul Severance, United Senior Action
Steve Albrecht, Indiana Health Care Association